GENERAL INFORMATION

AHCCCS has liability for payment of benefits after Medicare and all other third party payer benefits have been paid. Providers must determine the extent of the third party coverage and bill Medicare and all private insurance carriers, including HMOs, prior to billing AHCCCS.

AHCCCS maintains a record of each recipient's coverage by Medicare and private carriers. If a recipient's record indicates third party insurance coverage but no Medicare and/or insurance payment is indicated on the claim, the claim may be denied.

If attempts have been made to collect payment but the third party payer, including Medicare, has denied payment; a "Ø" should be entered in the appropriate Medicare/third party payment fields of the claim. This certifies that Medicare and/or the third party payer was billed but that no payment can be received.

Providers may not “zero fill” the Medicare fields on hospital inpatient and outpatient claims, dialysis facility claims, and hospice claims. If a claim is denied by Medicare, providers should submit documentation of the denial with the UB-92 claim to AHCCCS.

The initial claim must be submitted to AHCCCS within six months of the date of service, even if payment from Medicare or other insurance has not been received. The claim must also meet the 12-month clean claim time frame.

AHCCCS will not pay for more than the recipient’s financial responsibility for the service (e.g., any deductible, coinsurance, and/or co-pay).

As a Medicare provider, a provider must accept Medicare allowable as total compensation for services rendered. AHCCCS will reimburse up to the Medicare deductible, coinsurance, or co-pay for services rendered to recipients with Medicare coverage, including recipients enrolled with a Medicare HMO. Contact the Medicare HMO for information regarding covered services and prior authorization.

Services that are not Medicare-covered services but are AHCCCS-covered services (e.g., non-emergency transportation) may be reimbursed by AHCCCS if they are medically necessary and meet AHCCCS reimbursement requirements. However, Medicare-covered services that are disallowed by Medicare because they were not medically necessary or were not delivered in an appropriate setting will not be reimbursed by AHCCCS.

MEDICARE CROSSOVER CLAIMS

AHCCCS has established an automated crossover process for fee-for-service claims from providers whose Medicare carrier or intermediary is BlueCross/ BlueShield of North Dakota (Noridian), BlueCross/BlueShield of Arizona, and BlueCross/Blue-Shield of Texas (TrailBlazer Health Enterprises).

When a provider submits a claim to Medicare for an AHCCCS recipient who also is Medicare eligible, the claim is automatically crossed over to AHCCCS when Medicare issues payment. Providers should not submit claims to AHCCCS for paid Medicare claims for dually eligible AHCCCS recipients or QMB recipients. All Medicare crossover claims are identified on the provider's remittance advice.

Denied and adjusted Medicare claims are not automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS (See below) within six months from the date of the Medicare EOMB. A copy of the EOMB must accompany the claim to AHCCCS. These claims must achieve clean claim status within 6 months of the date of the Medicare EOMB, 12 months from the date of service, or 60 days of the last adverse action by AHCCCS, whichever is later, as long as the initial submission to AHCCCS was within 6 months of the date of service.

CMS 1500 CLAIMS WITH MEDICARE/OTHER INSURANCE

When a provider finds it necessary to file a CMS 1500 claim with AHCCCS for a recipient who also is covered by Medicare or other insurance, the provider must report Medicare and other insurance information on the claim to AHCCCS.

For recipients and services covered by Medicare

For recipients and services covered by Medicare, providers must bill Medicare first. When payment is received, providers may bill AHCCCS for the coinsurance and deductible as shown on the Medicare EOMB. The coinsurance and deductible information is entered in Field 24K.

24 A						B	C	D	E	F	G	H	I	J	K
DATES OF SERVICE From MM DD YY			To MM DD YY			Place of Service	Type Of Service	PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances CPT/HCPCS MODIFIER	DIAGNOSIS CODE	CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE

CMS 1500 CLAIMS WITH MEDICARE/OTHER INSURANCE (CONT.)

For recipients and services covered by Medicare (Cont.)

- ☑ Providers should divide Field 24K with a diagonal or vertical line and report *coinsurance* to the *left* of the vertical line or *above* the diagonal line.
- ☑ Providers should report *deductible* to the *right* of the vertical line or *below* the diagonal line.
  - ✓ If the deductible has been met, enter zero (Ø) for the deductible.
  - ✓ If only the coinsurance amount is entered in Field 24K, the amount is treated as a TPL payment, resulting in incorrect reimbursement.

Example 1: Provider reports coinsurance of $145 and deductible of $100.

K
RESERVED FOR LOCAL USE
145.00 / 100.00

or

K
RESERVED FOR LOCAL USE
145.00 | 100.00

Example 2: Provider reports $145.00 coinsurance and no deductible.

K
RESERVED FOR LOCAL USE
145.00 / 0

or

K
RESERVED FOR LOCAL USE
145.00 | 0

- ☑ If two amounts are reported without a line separating the amounts, the first amount will always be considered coinsurance and second amount will be treated as the deductible.

Example 3: Provider reports $145.00 coinsurance and no deductible.

K
RESERVED FOR LOCAL USE
145.00 0

- ☑ For recipients and services covered by other third party payers, enter only the amount *paid*.

Example 4: Provider reports payment of $105.00 from a third party payer.

K
RESERVED FOR LOCAL USE
105.00

CMS 1500 CLAIMS WITH MEDICARE/OTHER INSURANCE (CONT.)

For recipients and services covered by Medicare (Cont.)

☑ ***Always*** attach a copy of the Medicare or other insurer's EOB to the claim.

- ✓ Providers must submit a separate Medicare EOMB with each claim form.
- ✓ If a provider submits multiple claims for a recipient but includes only one copy of the Medicare EOMB, the EOMB will be attached to the claim with highest coinsurance and deductible amount.
- ✓ The other claims in the package will be denied for lack of a Medicare EOMB.

For recipients with Medicare coverage but the service is *not* covered by Medicare

☑ If the recipient has Medicare coverage but the service is not covered by Medicare or the provider has received no reimbursement from Medicare, the provider should "zero fill" Field 24K and submit the claim within the appropriate time frame.

- ✓ Leaving the field blank will cause the claim to be denied.
- ✓ Zeros indicate that no payment was received.
- ✓ If payment from Medicare or another third party is received after the provider has been reimbursed by AHCCCS, the claim to AHCCCS must be adjusted.

Example 5: Provider reports no payment received from Medicare.

K
RESERVED FOR LOCAL USE
0 / 0

or

K	
RESERVED FOR LOCAL USE	
0	0

or

K	
RESERVED FOR LOCAL USE	
0	0

Example 6: Provider reports no payment received from third party payer.

K
RESERVED FOR LOCAL USE
0

☑ If the service is a Medicare-covered service and the claim is denied by Medicare, the provider's claim to AHCCCS also will be denied unless the provider has obtained authorization from the AHCCCS Prior Authorization Unit.

CMS 1500 CLAIMS WITH MEDICARE/OTHER INSURANCE (CONT.)

The Medicare EOMB may combine each individual line charge into a single charge for the entire claim and issue payment based on the total charges. The EOMB may not show a coinsurance amount for each billed charge.

For AHCCCS to correctly process and reimburse claims, providers must follow these steps to prorate the total coinsurance amount and allocate it to each line of the claim.

1. Divide the coinsurance amount by the total covered charges allowed by Medicare as shown on the EOMB.
2. Multiply the charges on each line by the percentage calculated in Step 1.
3. Enter the prorated coinsurance amounts calculated in Step 2 on the CMS 1500.

Example 7: Provider submits a three-line claim to AHCCCS.

Total covered charges allowed by Medicare	$4,210.00
Medicare paid amount	$3,368.00
Coinsurance	$ 842.00

1. Divide the coinsurance amount by the total covered charges allowed by Medicare.

   842.00 ÷ 4,210.00 = .20 Coinsurance is 20% of total charges

2. Multiply the charges per line by the percentage calculated in Step 1.

Line	Billed charges X per cent	Prorated Coinsurance
1	2,900.00 X .20	580.00
2	270.00 X .20	54.00
3	1,040.00 X .20	208.00
Total	4,210.00 X .20	842.00

CMS 1500 CLAIMS WITH MEDICARE/OTHER INSURANCE (CONT.)

Example 7 (Cont):

3. Enter the amounts calculated in Step 2 on the corresponding lines of CMS 1500. If the deductible has been met, enter zero (Ø) on each line.

F	G	H	I	J	K
CHARGES	DAYS OR UNITS	EPSDT Family Plan	EMG	COB	RESERVED FOR LOCAL USE
2900 00	1		N	Y	580.00 | 0
270 00	1		N	Y	54.00 | 0
1040 00	1		N	Y	208.00 | 0
28. TOTAL CHARGE 4210 | 00		29. AMOUNT PAID			30. BALANCE DUE 842 | 00

☑ For other third party payers, perform the same calculations to the paid amount and enter only the prorated paid amount in Field 24 K.

UB-92 CLAIMS WITH MEDICARE/OTHER INSURANCE

When a provider finds it necessary to file a UB-92 claim with AHCCCS for a recipient who also is covered by Medicare or other insurance, the provider must report Medicare and other insurance information on the claim to AHCCCS.

For recipients and services covered by Medicare, providers must bill Medicare first. When payment is received, providers may bill AHCCCS for the coinsurance and deductible as shown on the Medicare EOMB. Providers must attach a copy of the Medicare EOMB to the UB-92 claim.

☑ Medicare Part A

- ✓ Report the Part A deductible and coinsurance (if applicable) amounts and appropriate value codes in Fields 39A and 40A.
- ✓ Use value code A1 to indicate Part A deductible and A2 for Part A coinsurance.

Example 8: Provider reports Medicare Part A deductible of $812 and no coinsurance.

	39 VALUE CODE			40 VALUE CODE			41 VALUE CODE		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a	A1	812	00						
b									
c									
d									

☑ Medicare Part B - Inpatient

- ✓ Report Medicare Part B as the payer and the Part B paid amount in Fields 50B and 54B.

Example 9: Provider reports Medicare Part B Inpatient payment of $312.

50 PAYER	51 PROVIDER NO.	52 REL 53 ASG INFO BEN		54 PRIOR PAYMENTS		55 EST AMOUNT DUE	
A							
B MEDICARE PART B				312	00		
C							

UB-92 CLAIMS WITH MEDICARE/OTHER INSURANCE (CONT.)

☑ Medicare Part B - Outpatient

- ✓ Report the Part B deductible (if applicable) and coinsurance amounts and appropriate value codes in Fields 39B and 40B.
- ✓ Use value code B1 to indicate Part B deductible and B2 for Part B coinsurance.

Example 10: Provider reports outpatient Part B coinsurance of $125.

	39 VALUE CODE			40 VALUE CODE			41 VALUE CODE		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a									
b	B2	125	00						
c									
d									

☑ Third party payers

- ✓ Report the third party's name and payment amount in Fields 50A and 54A or 50B and 54B.
- ✓ Attach a copy of the insurer's EOB to the UB-92 claim.

Example 11: Provider reports a third party payment of $1,225.00.

50 PAYER	51 PROVIDER NO.	52 REL 53 ASG INFO BEN		54 PRIOR PAYMENTS		55 EST AMOUNT DUE	
A XYZ Insurance				1,225	00		
B							
C							

Providers may not "zero fill" the Medicare fields on hospital inpatient and outpatient claims, dialysis facility claims, and hospice claims. If a claim is denied by Medicare, providers should submit documentation of the denial with the UB-92 claim to AHCCCS.

NURSING FACILITY CLAIMS WITH MEDICARE/OTHER INSURANCE

AHCCCS is responsible for reimbursement of Medicare coinsurance minus any TPL payment, minus the recipient's share of cost (SOC).

When a nursing facility submits a claim to Medicare Part A intermediaries BlueCross/BlueShield of Arizona and BlueCross/Blue-Shield of Texas (TrailBlazer Health Enterprises) for an AHCCCS recipient who also is Medicare eligible, the claim is automatically crossed over to AHCCCS when Medicare issues payment.

Nursing facilities should not submit claims to AHCCCS for paid Medicare claims for dually eligible AHCCCS recipients or QMB recipients. All Medicare crossover claims are identified on the provider's remittance advice.

When a recipient has exhausted the Medicare benefit for nursing facility coverage, the nursing facility must submit a claim to AHCCCS. The facility should "zero fill" the Medicare fields and submit the claim within the appropriate time frame. Leaving the fields blank will cause the claim to be denied. Zeros indicate that no payment was received.

Example 12: Provider reports no payment received from Medicare. Value Code A2 = Medicare Part A Coinsurance

	39 VALUE CODES			40 VALUE CODES			41 VALUE CODES		
	CODE	AMOUNT		CODE	AMOUNT		CODE	AMOUNT	
a	A2	00	00						
b									
c									

If payment from Medicare or another third party payer is received later, the claim must be adjusted.

Denied and adjusted Medicare claims also are not automatically crossed over to AHCCCS. These claims must be submitted to AHCCCS within six months from the date of the Medicare EOB.

A copy of the Medicare EOB must accompany the claim to AHCCCS. The claim must achieve clean claim status within 6 months of the date of the Medicare EOB or 60 days of the last adverse action by AHCCCS, whichever is later, as long as the claim was initially submitted within 6 months from the date of service.

RETROACTIVE POSTING OF MEDICARE ELIGIBILITY

Occasionally, AHCCCS learns that a recipient is eligible for Medicare after payment has been made to the provider. When that happens, AHCCCS recoups the money overpaid from future payments to the provider and advises the provider to bill Medicare.

AHCCCS also has contracted with Public Consulting Group, Inc. to identify inpatient hospital claims that are overpaid due to the late posting of Medicare eligibility.

AHCCCS has begun to systematically identify all members with retroactive Medicare posting for whom the agency has paid claims from both hospitals and other providers, without consideration of the potential Medicare payment. A report is reviewed monthly and allows AHCCCS to recoup any overpayments from all provider types.

When AHCCCS recoups, providers should bill Medicare and follow the procedure outlined earlier in this chapter.